# MEMO

## Questions and Answers
## Related to the New Hospice Conditions of Participation
## {Effective 12/2/08}

PATIENT RIGHTS

1) Is there any problem with agencies incorporating their agency grievance procedures in with the patient rights?
   A: No, there is no problem with an agency doing that.
2) Is the patient's signature required on a copy of the actual bill of rights or is it adequate to have a checklist, listing several documents given to the patient, marked with an "X" by "Bill of Rights"?
   A: The agency must obtain a signature confirming the patient received a copy of the patient's rights. This does not have to be a signed copy of the ***actual*** patient's rights. It can be another document such as a checklist described above.
3) When self-reporting a **verified** violation what number do we call?
   A: The hospice has 5 working days from becoming aware of a violation to investigate any alleged violations and, if the alleged violation is **verified**, it must report the **verified** violation to the State and local bodies having jurisdiction within those 5 days. The number to call is the Senior Services Hotline/24 hour number @ 1-800-392-0210. **(L511)**

MEDICAL DIRECTOR

1) Should there be just one "main" medical director? Does the main medical director have to be available at all times? What happens when an agency has 2 medical directors and they alternate coverage and IDT meetings every other week?
   A: There is only one Medical Director who supervises the other physician members of the IDG teams. The other physician members would continue to fill the role of the physician on each IDG team, such as certification/recertification and oversees the medical component of each patient's care. In other words, one physician has to have overall responsibility for the medical component of the agency, including all multiple locations and supervise the other physicians. There can only be one Medical Director (who must be clearly defined) but multiple physician members of the IDG teams. **(L669)**
2) Can the medical director act as the attending physician if the patient chooses and sign the election statement in both spots as the attending and the medical director?
   A: Yes, the medical director can also be the patient's attending physician. The medical director can sign the election statement both as the attending and the medical director. (Recently, Cahaba has confirmed and states there has been no recent changes regarding this practice.) It needs to be very clear in the medical record that the ***patient*** has chosen to use the medical director as his/her attending.

COMPREHENSIVE ASSESSMENT

1) Do agencies have to address everything on the updated comprehensive assessment every 2 weeks?
   A: The updates to the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending, if any) every 2 weeks. (Although the federal regulations state no less frequently than every 15 days, the state regulations are more stringent and require updates every 14 days). Therefore, this means there should be communication with the attending physician no less than every 2 weeks, every time there is an IDT meeting. It should address any changes in the patient's status; that is, physical, psychological, emotional, & spiritual (including bereavement) issues. It should also address the patient's response to care and any information regarding the patient's progress toward outcomes. Hospices are required to identify and document if there were no changes in the patient/family condition or needs. Hospices are free to choose their own method for documenting updates to the assessment. The IDG note every 2 weeks could be considered the comprehensive update. If used it would need to be labeled as the "Update to Comprehensive assessment" as well as the IDG note and must be addressed in the agency's policy and procedures as such. **(L533)**
2) Can the on-going plan of care be the comprehensive assessment as long as you address it every 14 days?
   A: At the Federal Surveyor Training in Baltimore, MD, CMS stated the intent of the regulation is that these are two separate documents. The updated assessment reflects what has occurred with the patient in the last 14 days and their response to care and the plan of care addresses the patient's current and future needs. Please refer to 42 CFR 418.54 and 418.56(b) and (c) for detailed explanations.
3) What does "communication" with the attending physician mean?
   A: The patient may or may not have an attending physician. If the attending physician is unavailable or unresponsive, the hospice physician must assume this role. If the patient does have an attending physician, one or more members of the IDG should consult with this physician in completing the comprehensive assessment. This consultation can occur through phone calls or other means of communication (Fax, e-mails, text messages, etc.) and will help to acquire a better understanding of the patient and family. The communication does not have to be face-to-face. Attending physicians can often provide a history of the patient's disease process and family dynamics that can help the hospice make better care planning decisions that address all areas of need related to the terminal illness and related conditions, resulting in improved patient outcomes. **(L523)**
4) Please clarify….The IDG has to complete the comprehensive assessment within 5 days, is this 5 days after the election statement is signed?
   A: Yes, it is 5 days after the election statement is signed. The "election of hospice care" is the effective date of the election statement. The patient may sign the hospice election statement with a later (not earlier) effective date. Hospices may choose to complete the comprehensive assessment earlier than 5 days after the effective date of the election (e.g., it may complete the comprehensive assessment at the same time the initial assessment is completed.) **(L523)**
5) What will the surveyors look for to ensure that the comprehensive assessment is being reviewed by the whole IDG team? Is a signature by each team member required?
   A: Each team member does not have to have an actual signature on the comprehensive assessment. The surveyors would look for, however, some type of attendance sheet that was signed by each team member that attended.

INITIAL ASSESSMENT

1) Is it true the RN has to complete the initial assessment within 48 hours instead of 24 hours?
   A: The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours. The hospice must meet the patient's immediate needs; therefore, if the patient needs care prior to the 48hours it is expected that the initial assessment be done in less than the 48 hour requirement. **(L522)**
2) If a patient is hospitalized and elects hospice on discharge, can the hospice do the initial assessment on or before the day of discharge while the patient is still in the hospital?
   A: No, the initial assessment can only be done while the patient is in the hospital if the hospice is admitting them to "inpatient" hospice care. The assessment needs to take place in the location where hospice services are being delivered. Therefore, if they are admitting the patient to "routine" home hospice, the initial assessment must be done in the patient's place of residence. The initial assessment is not a "meet and greet" visit whereby the hospice introduces itself to the patient/family and begins to evaluate the patient's interest in and appropriateness for hospice care. It must assess the patient's immediate physical, psychosocial, emotional and spiritual status related to the terminal illness and related condition. The initial assessment is necessary to gather the essential information necessary to begin the plan of care and provide the immediate necessary care and services. The registered nurse must conduct this initial assessment. Hospices may choose to send a social worker or other discipline along with the RN to complete the initial assessment. **(L522)**
3) Does the initial assessment include assessing the patient for psychosocial and spiritual needs?
   A: Yes, the initial assessment must identify psychosocial & spiritual needs. The registered nurse may do the psychosocial and spiritual assessment but the IDG should address the needs identified. The social worker and chaplain would guide the psychosocial and spiritual care. Remember, the state regulations require spiritual assessment by the spiritual counselor and a psychosocial assessment by the social worker within 7 days of signing the election statement.

INPATIENT HOSPICE

1) Staffing: If the hospice has a census of 21 – 29 patients and the staff can meet the patient's needs with 2 employees, does this suffice ***state*** regulations?
   A: Yes, but of utmost importance is that the staffing ratio must be such that the patient's needs can be met. If the patient's needs cannot be met with 2 employees, it would be expected that a third (or however many is needed) would be added. Once you reach 30 patients the number of staff would have to be increased to **at least** 3. **(ML304).**

2) If hospice is billing for patients under general inpatient care, do you need to have an RN on duty at all times?
   A: The new federal regulations **(L723)** states, "If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care." Even though the state regulations (ML307) state "a registered nurse shall be available for telephone consultation or onsite visit as needed 24 hours a day", the hospice must follow the more stringent.

CRIMINAL BACKGROUND CHECKS

1) Clarify the extent of criminal background checks…is it all employees, including receptionist, accounting, billing, etc?
   A: Per Missouri *state* regulations, all employees having patient and/or clinical record contact would require a criminal background check.
2) Per the new federal regulations, does criminal background checks apply to anyone who works for the hospice whether an "employee or a contracted staff, such as a DME company, or pharmacy?
   A: The federal regulations do apply to all employees of the agency. At this time there is no definite answer from CMS regarding such contracted entities as DME companies or pharmacies. Per CMS the standard has to be re-written. The newly written standard will come out sometime in the spring of 2009 for comments and then be fast-tracked in order to be published by fall 2009.

BEREAVEMENT

1) Can bereavement follow-up be via internet or emailing instead of phone calls or cards?
   A: CMS's response to this question was that they could not imagine what kind of bereavement counseling would be done by e-mail. However, no definitive answer was given. Therefore, the surveyors will be looking at this on a case-by-case basis at the time of survey. It is felt that this should not be a routine practice; however, we do understand how a family member may ask to correspond with your agency via e-mail. The surveyors would expect good documentation of this. The surveyors would also expect the hospice to follow agency policy.

RESTRAINTS

1) Do the regulations on restraints only apply to in-patient or respite in nursing homes?
   A: Yes
2) Do the regulations on restraints **(L737)** correlate with hospital regulations?
   A: These regulations are based on the hospital regulations.

IDG

1) Is it correct that only one IDG is responsible for policies and procedures? How will surveyors look for this?
   A: Yes, one IDG is responsible for policies and procedures. If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services. If the hospice has more than one IDG, it may select members from different IDGs to serve on the IDG that establishes the hospice's policies, as long as all required disciplines are represented (e.g., physician, RN, social worker, counselor). **(L542)**
2) Does the member of the IDG that is designated to provide coordination of care and to ensure continuous assessment of each patient/caregiver have to be a registered nurse?
   A: The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's need and implementation of the interdisciplinary plan of care. This registered nurse must assure that all members of the IDG are kept informed of the patient/family's status. **(L540)**

3) Can one person fill dual roles on the IDG? If the registered nurse is also a qualified social worker can he/she fulfill both roles?
A: Yes, the number of individuals on the IDG is not as important as their qualifications and abilities. For example, if a group member meets the hospice criteria and is licensed as a registered nurse and also meets the Medicare criteria to be considered a social worker under the hospice benefit, he/she would be qualified to serve on the IDG as both a nurse and a social worker**. (L541)**

SKILLED NURSING FACILITIES

1) Please define and clarify. Can hospices work together in providing training for skilled facilities (SNF) so the SNFs don't have to allow numerous different hospices to orient the skilled facility staff?
A: Hospices may combine their efforts and present one generic hospice in-service. However, each hospice is responsible for the initial in-servicing of the facilities regarding their policies and procedures for admissions, documentation (appropriate forms and record keeping), communication/coordination/collaboration, etc. The bureau's interpretation of CMS's response is that each hospice must be able to show they have oriented every facility they go into regarding the above. Then the hospices may present combined in-services after that. It is the hospice's responsibility to determine how frequently training needs to be offered in order to ensure that the facility staff furnishing care to hospice patients are oriented to the philosophy of hospice care. Facility staff turnover rates should be a consideration in determining training frequency.
2) Does the person designated as responsible for providing overall coordination with the skilled nursing facility have to a registered nurse?
A: The intent of this regulation is for the hospice IDG to designate a member responsible for overseeing and coordinating the provision of care between the hospice and the facility. This person may or may not be the hospice RN responsible for the coordination of patient's hospice care in the facility. It may also be the physician, social worker, chaplain, or counselor member of the IDG**. (L778)**

DRUGS

1) The new regulations state the hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures. Can the medical director fulfill this role?
A: Hospices must confer with an individual with education and training in drug management, and use acceptable standards of practice for hospice patients to select the most appropriate drugs to meet a particular patient's need. Conferences may take place in person or through other means of communication (e.g., teleconference, FAX, electronically, etc.). Individuals with education and training in drug management may include: licensed pharmacists; physicians who are board certified in palliative medicine; RNs who are certified in palliative care; and physicians, RNs and nurse practitioners who complete a specific hospice or palliative care drug management course, and other individuals as allowed by State law**.** The bureau has determined that, if it is your agency's policy that the medical director and/or attending physician are responsible for the drug management of the patient, that physician would be allowed to fulfill the role mandated by this regulation. **(L688)**

SCOPE OF LIMITATIONS

1) Does the patient have to be provided in writing information about the scope of services that the hospice will provide and specific limitations on those services?
   A: Yes. Hospices are required to fully inform Medicare patients about all Medicare covered hospice services and fully inform non-Medicare patients about any other hospice services that apply to the patient. Hospices are required to provide all hospice services necessary for the palliation and management of the terminal illness and related conditions and should not accept patients if they cannot provide these hospice services. The surveyors would expect to see, in writing, something provided to the patient explaining to them what is covered and what is not. **(L518) (L519)**

AIDES

1) Is it true the agency must perform an annual on-site supervisory visit with each aide?
   A: Yes, a registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. No less frequently than every 14 days a registered nurse must make an on-site visit to the patient's home; however, the hospice aide does not have to be present during this visit. **(L629) (L632)**
2) Who develops the aide plan of care?
   A: The hospice aide provides services that are ordered by the interdisciplinary group. The written patient care instructions for the hospice aide must be prepared by a registered nurse who is responsible for the supervision of the hospice aide. **(L625) (L626)**
3) Do the new federal hospice regulations change the qualifications required of the nurse aide working in a hospice agency in the state of Missouri?
   A: No. The qualifications for a hospice nurse aide has not changed. It is still required that, in order to work as an aide in hospice, he/she must pass the Missouri state aide competency exam and skills test.
4) Who supervises the nurse aide in hospice?
   A: The aide is supervised by the registered nurse. Physical therapy cannot supervise the aide in hospice.

VOLUNTEERS

1) If a volunteer provides personal care to a patient does the volunteer have to meet all the aide competency requirements?
   A: Yes. All required volunteer training should be consistent with the specific tasks that volunteers perform. Therefore, is a volunteer functions as an aide, he/she must have passed the state competency exam and skills test as required by the state for all nurse aides. Qualified volunteers who provide professional services for the hospice must also meet all requirements associated with their specialty area. If licensure or registration is required by the State, the volunteer must be licensed or registered. The duties of volunteers used in direct patient care services or helping patients and families must be evident in the patient's plan of care. **(L643) (L644)**

DIETARY

1) Can a hospice agency contract for dietary services?
   A: No, a hospice agency cannot contract for dietary services. Per 42 CFR 418.64 Condition of Participation: Core Services, dietary counseling (a counseling service) is considered a core service. Per **L588,** a hospice must routinely provide substantially all core services **directly** by hospice employees. In other words, the person who provides dietary counseling would be required to be issued a W -2 form. Per CFR 418.74, **L606** a hospice may seek a waiver of the requirement that it provide dietary counseling directly but it requires specific and very stringent requirements to be met. These specific requirements are listed in the interpretive guidelines under CFR 418.74.

COORDINATION OF SERVICES/COMMUNICATION

1) How does the hospice assure that there is good coordination of care between the IDG (including the attending physician) members?
   A: The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures to: 1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervision the care and services provided, 2) Ensure that the care and services are provided in accordance with the plan of care, 3) Ensure that the care and services provided are based on all assessments of the patient and family needs. 4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement and 5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.
   The surveyors would expect to see documentation in the clinical record of the sharing of information between all disciplines providing care and with other healthcare providers furnishing services to the patient. **(L554) (L555) (L556) (L557) (L558)**
2) How often should the clinical record show communication of information between the IDG members?
   A: The clinical record should show communication and flow of information between IDG members (including the attending) after the initial assessment and then if ever there is an update to the plan of care. If there is not a lot going on with the patient this could be just every 14 days at the IDG meetings.

PHYSICIAN SERVICES

1) Are physician assistants recognized in hospice?
   A: No

NURSE PRACTITIONERS

1) If a patient has chosen a nurse practitioner as his/her attending physician, who will certify the patient?
   A: If the patient has chosen a nurse practitioner as the attending, the medical director may certify the patient for hospice care.

DURABLE MEDICAL EQUIPMENT

1) Please explain what is required for DME companies with the new regulation?
   A: Effective September 30, 2009, hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR 424.57.
   DMEPOS is the acronym for Durable Medical Equipment Prosthetics, Orthotics and Supplies. All DMEPOS suppliers are required under separate rulemaking to be accredited by September 30, 2009, in order to receive Medicare payment. If a hospice has a contract with a DME supplier (that has a Medicare supplier billing number), the hospice should have a letter in its file from the DME supplier stating that the DME supplier is accredited.
   If the hospice contracts with a DME supplier that only serves hospices, (therefore, no Medicare supplier number), the hospice will still need to have a letter in its file from the DME supplier stating that the DME is accredited.
   If the hospice owns its own DME, no accreditation is needed.

INPATIENT DAYS

1) The number of inpatient days are not to exceed 20% of total hospice days. Does this percentage only apply to ***Medicare*** inpatient days? Does this include respite days?
   A: Per 42 CFR 418.108(d), regarding number of inpatient days, not exceeding 20% of total number of hospice days, applies only to the percentage of total number of MEDICARE inpatient days in relation to total number of Medicare patient hospice days. This is only for general inpatient days, not respite days.